Referrals can be made by faxing this form or calling the office.

Date: ___________________________ Number of Pages: ___________________ 

☐ Armen Choulakian, M.D.  ☐ Yu-Hung Kuo, M.D.  ☐ Nicholas Levine, M.D.  
☐ Amir Khan, M.D.  ☐ Derek Taggard, M.D.  ☐ Jonathan D. Grossman, M.D. (Interventional Pain Management)  
☐ Mark Levy, M.D.  ☐ Ian Johnson, M.D.  
☐ Nathan Deis, M.D.  ☐ First Available Physician

REQUIRED PATIENT INFORMATION
☐ Santé Referral  
☐ Last Pain Management Note if Completed
☐ Insurance Auth (Ex: TRICARE, Worker’s Comp, etc.)  
☐ EMG/NCV Report if Completed
☐ Worker’s Compensation (Claim Number, Date of Injury, Adjuster/NCM Name and Contact Info)  
☐ Neurology Consult Report if Completed
☐ Copy of Insurance Card/Demographic Sheet  
☐ Patient’s Height
☐ Last Chart Notes  
☐ Patient’s Weight
☐ Last Physical Therapy Note if Completed  
☐ MRI/CT Done in the Last 6 Months

Protocol for Brain Tumors: For any brain tumors that may be compromising the patients vision, visual field tests should be ordered/completed prior to appointment scheduling.

Protocol for Pituitary Tumors: Patients with this diagnosis should complete the following labs prior to appointment scheduling: prolactin, electrolytes, TSH, T4, ACTH, cortisol, urine cortisol and IGF1.

**NOTE All information and radiology images are needed to schedule an appointment.

Referring Physician: ___________________________ Phone: ___________________________

PCP (if different from referring): ___________________________ Phone: ___________________________

Patient Name: __________________________________________

Patient Home Phone: ___________________________ Patient Cell: ___________________________

Consultation for: __________________________________________

Diagnosis: __________________________________________

Insurance: __________________________________________

IMPORTANT INFORMATION

Office Policy states that any imaging that was not performed at Advanced Medical Imaging, California Imaging, CRMC, Clovis Community or Sierra Imaging must be hand carried by patient to their appointment.

Images, related to the diagnosis, must have been taken within 6 months of the referral. Insurance authorization must also be sent with the referral.

Contact Person: ___________________________ Title: ___________________________

Phone: ___________________________ Fax: ___________________________

Comments: __________________________________________

Thank you very much for referring your patient to our office.

Additional questions, please contact our Referrals Department at 559.256.9622

Fax Referrals to Sylvia at 559.256.4432
University Neurosciences Institute
45 River Park Place West, Suite 104, CA 93720
559.320.0530 // 559.320.0532 fax

We are located on the first floor of the University of Phoenix building next to the Fresno Heart & Surgical Hospital.

When traveling from the North:
Take the 41 Highway South and exit on Friant Ave. Take Friant Ave. East to North Fresno St. Make a left turn at North Fresno St and drive North until you come to a stop sign which will be River Park Place. Make a left at the stop sign and follow the road until you reach our location on your left hand side.

When traveling from the South:
Take the 41 Highway North and exit on Friant Ave. Take Friant Ave. East to North Fresno St. Make a left turn at North Fresno St and drive North until you come to a stop sign which will be River Park Place. Make a left at the stop sign and follow the road until you reach our location on your left hand side.